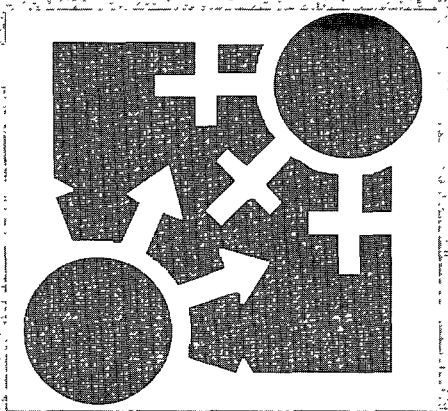
Research Gaps Related to Gender Issues and Population, Health, and Nutrition Programs

Summary of an Analysis

April 2000



Research and Indicators Subcommittee
Interagency Gender Working Group

IGWG

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I. Introduction

As family planning programs expand to include more components of reproductive health, many seek to do so using a gender perspective. Gender, or the socially defined roles and status of women and men in societies and the relative power women and men have associated with their roles, is an important determinant of women's and men's reproductive health.

Simply acknowledging that a gender perspective is important, however, does not provide clear guidance on how to make changes in programs. Research, including biomedical, policy/programmatic, and social science studies[1], can help programs make changes that empower women and men to exercise their reproductive rights and meet their reproductive goals and to promote gender equity.

The subcommittee on research and indicators of the USAID Population, Health and Nutrition Interagency Gender Working Group (IGWG) has compiled a list of research gaps associated with gender and reproductive health.

This summary of a longer document first outlines the fundamentals of "gender-sensitive" reproductive health research. Second, the summary highlights the gender issues related to fifteen aspects of reproductive health that were included in the 1994 International Conference on Population and Development (ICPD) and the 1995 Fourth World Conference on Women (FWCW) agendas.[2] Third, the summary contains a short bibliography of research studies on the topic that best exemplify a gender perspective. Finally, the summary contains a matrix that includes the top three to five gender-related research issues for each aspect of reproductive health.

[1] Biomedical research includes studies of the physical, medical, and technological aspects of reproductive health. Policy and programmatic research includes studies of policies, guidelines, and regulations and the service delivery system and practices that support reproductive health services. Social science research includes studying the sociocultural dynamics of reproductive health choices, practices, and outcomes.

[2] This analysis does not include men's reproductive health as a separate component because the IGWG has a separate subcommittee on men that has compiled its own list of research gaps.

II. "Gender-Sensitive" Reproductive Health Research

There is general agreement that reproductive health research should attempt to be "gender-sensitive." But what does this mean? We propose some ideal characteristics of gender-sensitive research.

Some research studies gender issues while other intervention research has more explicit gender-related goals, such as testing approaches to enrolling and keeping more girls in school or to making women more aware of their rights or to encouraging more men to seek reproductive health services for themselves or for their partners. Some intervention research seeks to improve provider-client interactions, while others seek to get couples to better communicate about reproductive health issues or to use male or female condoms for STI/HIV prevention.

The suggestions below apply to research whether it is formative, intervention or evaluation research and whether it deals directly or indirectly with gender issues.

A. Research Design and Conceptualization

Gender-sensitive research uses a gender analytic framework to outline the research questions, for example, the frameworks of Moser (1989), Oppong (1980) or the Women's Studies Project (Hardee et al., 1996).[3] Gender-sensitive research can also involve simply thinking through potential gender issues thoroughly before proceeding with the research. Gender-sensitive research also:

- Views women and men as part of families and communities and looks at people's lives in a holistic way, considering their options, quality of life, experiences, and perceptions. It is attentive to relations between and among men and women including differences in status, power and roles, vulnerability, access to resources, and physical traits.
- Considers how gender roles vary by age and life-cycle stage, social and economic status, ethnicity, religious affiliation, and other social characteristics and is aware that relationships between women and men can vary by situation and activity (e.g., women may have power to make only certain kinds of decisions and in some societies, older women are accorded higher status than younger women).

[3]Moser, CO. 1989. "Gender Planning in the Third World: Meeting the Practical and Strategic Gender Needs." *World Development.* 17(11): Pp. 1799-1825. Oppong, C. 1980. "A Synopsis of Seven Roles and Status of Women: An Outline of a Conceptual and Methodological Approach." *World Employment Programme Research Working Paper.* WEP 2-21/ WP.94. Geneva: International Labour Office. Hardee, K, P Ulin, S Pfannenschmidt and C Visness. 1996. "The Impact of Family Planning and Reproductive Health on Women's Lives: A Conceptual Framework." *Women's Studies Project Working Paper WP96-02.* Research Triangle Park, NC: Family Health International.

- Seeks to involve both women and men as study participants as well as researchers and encourages women and men to speak for themselves about topics of interest to them.
- Involves women and men, whenever possible, in study design, implementation, and interpretation of results. Involving women's (or men's) health advocates can be especially helpful in making sure the research is relevant and sensitive to people's experiences. It uses more integrated research strategies that draw on the combined strengths of both qualitative and quantitative research methodologies to enrich the gender-related findings.

B. Data Collection, Analysis, and Dissemination

Some of these characteristics of gender research could be considered general principles of good ethical research. The ethical issues are included here because they are so closely tied to gender issues. Gender-sensitive research investigates topics that are relevant to local needs and problems, not just those of interest to the investigator. It does not just collect data for the sake of professional publications but to improve the welfare of study participants. Gender sensitive research also:

- Considers whether gender training would be beneficial for research staff, including interviewers.
- Acknowledges the power differences between researchers/interviewers and study participants, as well as between providers and clients, and that these differences can lead to poor treatment on the part of the less powerful party.
- Incorporates, where possible, multiple methods of data collection, including qualitative data to allow women and men to tell their stories in their own words, and retests all study instruments to make sure that questions are clear and sensitively worded.
- Considers whether compensation of study participants is appropriate and if so, what level of compensation would be fair but not coercive.
- Puts a strong emphasis on informed consent (whether oral or written) and the need to respect the privacy and confidentiality of any information provided. All the research staff (interviewers, clerks, drivers, etc.) and not just the principal investigator need to be imbued with a concern for protection of human subjects.
- Does not burden study participants in terms of the time required, scheduling of interviews, or invasiveness of questions; each question asked should have a purpose and be essential to the analysis.
- Explains to potential respondents that their participation is voluntary, they will suffer no negative consequences if they do not participate, and they do not have to answer any question they feel is inappropriate.
- Uses the terms "gender" and "sex" thoughtfully with the former referring to the socially constructed roles expected of males and females, and the latter referring to biologically determined characteristics.
- Makes a "good faith" effort to convey the research findings back to study participants in a user-friendly fashion, ideally using multiple approaches and to disseminate results to people in a position to improve local conditions.

III. Issues Related to Gender and Components of Reproductive Health

Here we present the gender issues related to each component of reproductive health that will require further investigation. The "short list" of identified priorities in research gaps appears in the matrix at the end of this summary.

A. Adolescents

At the ICPD and FWCW, countries resolved to "protect and promote the rights of adolescents to sexual and reproductive health information and services" (UN 1994; UN, 1995) through reproductive health programs for adolescents. These programs should include, among a number of other components, counseling on gender relations, violence, and sexual abuse against adolescents, and responsible sexual behavior for both sexes.

The UN resolutions underline the fact that adolescent sexual and reproductive health care needs are not being adequately met. This is in part because their needs are not clearly understood within the social and cultural (including gender) context of their lives, but also because researchers, service providers, and policy makers often avoid the sensitive issue of adolescent sexuality or hold uncompromising attitudes toward adolescent sexual behavior, particularly for girls. Furthermore, because of age, immature physiology and gender, young women—both married and unmarried—are particularly vulnerable to exploitation that in turn leads to significant reproductive health problems.

B. Behavior Change Communications

Approaches to health communication within reproductive health programs are changing as a result of the HIV/AIDS pandemic, the global women's movement, and ICPD. Because behavior change communication (BCC) programs try to affect the normative environment which influences behavior, these programs can contribute to women's empowerment, fostering a process that challenges gender relations within communities and societies.

As a strategy in promoting reproductive and sexual health and rights, BCC may have somewhat different implications for women and men, depending on the health issue to be addressed. But whether a communication program works at the interpersonal, community, or mass media level (or at a mix of levels), we need to ask who participates in the design, implementation, and evaluation of the program. We also need to look at the assumptions made about gender norms and how existing BCC programs can and do address and affect gender norms.

C. Child Survival

Child survival strategies have generally included targeting preventative services in the community, such as immunization, water purification, sanitary

practices, and preventative caretaker behaviors, such as breastfeeding and hygiene. Still, more attention needs to be paid to gender issues and their impact on child survival. Gender disparities between girls and boys and how this affects their differential health profiles, both during childhood and later in the life cycle, have yet to be fully explored.

The benefits of programs that specifically address gender disparities and provide girls with opportunities for education, sexuality education and improved health and nutrition need to be documented as girls grow older and enter adulthood. In addition, many undocumented childhood health hazards, such as pesticide exposure, affect both boys and girls. Pesticide exposure may potentially have negative reproductive health consequences when the child reaches puberty and later in the life cycle. The long-term outcomes of such hazards to children should be the subject of future research.

D. Environmental and Occupational Health

Gender issues related to environmental and occupational health have received little attention to date. The major foci for work in environmental health have been diarrheal disease, malaria, and acute respiratory infections. However, many major environmental health issues, that affect the reproductive health of millions of people, have important implications for a gender perspective. These health issues include pesticide exposure among men, women, and male and female children who work in the fields planting and harvesting crops; exposure to hazardous wastes, and; occupational exposures to environmental hazards in assembly and manufacturing plants and other industrial settings.

Not enough is known about the effect of exposure to environmental and occupational hazards on reproductive health, particularly pregnancy and incidence of miscarriages. Research on these issues has often lacked a gender perspective.

E. Female Genital Cutting

Female genital cutting (FGC) is a harmful traditional practice that has existed for thousands of years and continues to be performed. The ritual, performed on girls at different ages, ranging from a few days old to puberty, comprises a variety of surgeries that include clitoridectomy, excision, and infibulation.[4] The research done on FGC so far has concentrated on how it is done, its prevalence, health consequences, and attitudes towards this practice.

Gender relations and the social construct within which women's sexuality and reproduction has been controlled has rarely been addressed, and serious consideration of including men in the debate to stop the practice came only a few years ago. Men's participation in the elimination efforts will help create a movement toward the recognition of women's rights to their bodily integrity; studying how best to involve men is also important because they monopolize the religious discourse.

F. HIV/AIDS/STIs and Condom Use

Gender issues related to HIV/AIDS are manifold and complex. In many societies, women lack the power to make decisions about how, when, and under what conditions they wish to engage in sexual relationships; this places them at risk for HIV/AIDS. Many women fear violence if they deny their sexual partner(s) unprotected sex, but for women, unprotected sexual relationships are key to economic survival for themselves and their children. Worldwide, millions of women are at risk of HIV largely because their only sexual partner may have multiple partners; yet these women have been largely ignored in public policy, such as the World Bank's *Confronting AIDS: Public Priorities in a Global Epidemic* (1997).

[4] For more information on classification see Female Genital Mutilation, Report of the WHO Technical Group, 1996.

In many societies, sexual knowledge is taboo for women before the initiation of sexual intercourse. Most of the world's health services have yet to effectively incorporate information on STIs and HIV/AIDS prevention, intervention, management, diagnosis, testing, and counseling into programs that reach out to women who may be at risk yet are not considered high risk. Commercial sex workers have traditionally been seen as vectors of transmission rather than deserving of health services, yet few health programs address the needs of commercial sex workers or offer them training to pursue other means of economic survival. Studies have shown that HIV risk reduction efforts, with outreach to women separately prior to interaction with men, can be effective, either in community-wide efforts or as part of small group interventions (Gupta and Weiss, 1998; Ickovics and Yoshikawa, 1998).

G. Infectious Diseases and Reproductive Health

Gender issues related to infectious diseases and reproductive health are important to investigate. International organizations such as Canadian International Development Agency (CIDA) and the World Health Organization's Tropical Disease Research (WHO/TDR) have paved the way in research concerning gender and infectious disease. For example, tuberculosis is now the single biggest infectious killer of women in the world, due in part to increased rates of HIV and the association between TB and HIV. There are important gender aspects to certain research questions that have yet to be addressed, as applying a gender perspective to infectious disease is a relatively new and uncharted challenge.

H. Infertility

It is estimated that 1 in 12 couples worldwide has difficulty conceiving a child. In some parts of the developing world, particularly in parts of Africa, the incidence of infertility due to the prevalence of STIs is even higher. Infertility is one of the most neglected aspects of reproductive health, and yet the ability to conceive, carry and produce a child is the focal point of reproductive health for most women worldwide. In many societies, women can be divorced or the husband may take another wife if they are unable to produce children in a union.

The assumption that infertility treatments are too expensive to offer to the general public, coupled with the reluctance of many people who are facing infertility to speak out on the issue, have combined to take infertility off the table in discussions of packages of reproductive health services in most countries. The gender issues related to infertility include: 1) attitudes towards women's and men's contribution to infertility (generally women are "blamed" for the infertility problem); 2) attitudes towards women who seek fertility treatments (that they become somehow unbalanced); and 3) the different treatment of women who are unable to conceive and their partners (who are not assumed to be the cause of the infertility in most societies).

I. Postabortion Care

Postabortion care (PAC) consists of three specific components: provision of emergency care services for complications caused by an incomplete spontaneous abortion (miscarriage) or by an unsafe induced abortion (pregnancy termination), postabortion family planning counseling and services, and links between emergency PAC treatment and reproductive health care. In general, most *gender* issues in PAC emerge from the circumstances that brought about an unwanted pregnancy and a subsequent clandestine termination. Women's difficulties in avoiding unwanted or mistimed pregnancies, the lack of women's legal access to a safe termination of a pregnancy, their need to resort to an unsafe and demoralizing 'medical' procedure, the secrecy and shame associated with abortion, and the legal ramifications—are all *gender* issues.

J. Postmenopausal Women

Gender and reproductive health issues relating to postmenopausal women have received little attention within the development community, although more than half of the world's women aged 60 years and older live in developing regions, and importance of these issues will only continue to grow as the number of postmenopausal women increases.

Circumstances that make menopause a different experience in the developing world, such as under-nutrition, repeated episodes of infectious disease and a lifetime of exposure to agricultural pesticides or indoor air pollution, have not been explored. In developing countries, nutritional deficiency of the general population is even more pronounced in aging women; years of child bearing and sacrificing her own nutrition for that of her family often lead to chronic anemia. And because of postmenopausal women's reduced importance in some cultures, improving a household's access to food does not guarantee that older women in the family will receive sufficient food or nutrition. Postmenopausal women remain sexually active, although in some cultures it is a taboo subject. The women in this group are still at risk of (and are) contracting STIs or HIV/AIDs, due in part to a lack of programs targeting reproductive health messages to them. Often there is a reluctance by families to provide resources necessary for medical needs, and there are few reproductive health programs and few trained medical personnel addressing the needs of this cohort.

K. Quality of Care

Most gender issues related to quality of care arise from the assumptions made by program staff about women's and men's preferences and need for information and services, and the unequal power relations between staff and clients. Prior to the movement to improve quality of care in family planning (and now in reproductive health), services were designed largely for the convenience of program staff, and women particularly were not considered competent to share in decisions related to their own care. In family planning programs, information given to clients on choice of methods, side effects, mechanisms of action, and follow-up care was generally not complete for fear of dissuading clients from using family planning. Furthermore, in many cases the language used by providers in interacting with clients was (and still is) condescending and disempowering. Finally, women's generally low status in most societies led family planning programs to be implemented for the purpose of lowering fertility (frequently by promoting female use of long-term and permanent contraceptive methods).

While quality of care has been the topic of a number of research studies, various gaps remain related to gender and each of the elements of quality of care: choice of methods, information provided to clients, interpersonal relations and use of language, technical competence, continuity of care, acceptability, and appropriateness of care, and, in a closely related topic, access to care.

L. Reproductive Health and Reproductive Rights

The ICPD and FWCW recognized that realization of the rights of women and men to the highest attainable standard of reproductive and sexual health is central to any population and development policy. The literature on human rights and reproductive health remains largely conceptual and establishes that the current global and regional human rights regimes—treaties, statements, and mechanisms for redress—already contain the foundation on which a human rights approach to improving reproductive health can be built. Beyond this conceptual work, there remain gaps in research looking at gender-related determinants of poor reproductive health *specifically from a human rights standpoint.* In particular, examination of gender-related discrimination as it pertains to women's ability to access and utilize economic, social and political resources has only recently

been recognized by both the reproductive health and human rights communities as critical for policies and programs to improve the reproductive and sexual health of women and men.

The main utility of a human rights approach is that governments can be held accountable to treaty obligations and other international commitments, such as the ICPD Programme of Action.

A complete rights/reproductive health research agenda would define for each right[5] whether people have the ability to fulfill this right and thus whether the government has fulfilled its duties, and if not, why, and how it could do so.

M. Safe Motherhood

The gender issues surrounding prenatal care, safe delivery, postnatal care and breastfeeding are more difficult to define than for infertility or STI, because only women can become pregnant, go through the birthing process and breastfeed. This is not to say, however, that the issues surrounding pregnancy, childbirth and the postpartum period are not linked to gender, or that gender considerations are not important for these issues. As with postabortion care, many of the gender issues in prenatal care, safe delivery, postnatal care and breastfeeding could arise from the circumstances that brought about the pregnancy in the first place: women's lack of power with her partner, lack of access to contraception and/or other health care services, or under-education when compared with male counterparts in the same society, among other factors.

What also makes the prenatal care issue particularly difficult is that there are no good predictive indicators of at-risk pregnancies, although this topic has been studied extensively. Because of this, all pregnancies must be considered at risk. However, there are ongoing studies concerning community and/or family empowerment through community knowledge of danger signs during pregnancy.

There is evidence of the impact men have on issues such as attaining prenatal care in a timely manner, decisions about transportation and how this affects timeliness of transport in emergencies, and the propensity to breastfeed. The importance of the male partner's role in allocation of family resources, for pre- and postnatal care and transport issues, cannot be underestimated and needs further attention. Other gender issues, such as the fact that in some cultures the husband must be involved in placenta rituals keeping the woman from seeking medical care away from the village, also need further recognition and study. There is still a need to concentrate on the cultural constraints gender imposes prenatal care, safe delivery, postnatal care, and breastfeeding, particularly in developing countries.

N. Violence Against Women

Gender-based violence is a pressing human rights and public health concern. Well-conducted research on gender-based violence is vitally important to efforts to combat violence and to create an environment in which women can fully exercise their rights to health and safety. A greater understanding of violence against women within and across cultures will facilitate the design of cost-effective and appropriate prevention, intervention and treatment programs, and will galvanize efforts to address gender-based abuse.

Because of the sensitive nature of abuse, researching violence against women raises both ethical and methodological issues. Poorly done studies can endanger the safety of participants and researchers and can compromise data quality. Studies of violence need new and better instruments for measuring the prevalence, severity and health consequences of abuse. The instruments

[5] The rights are found in the Universal Declaration of Human Rights (UDHR), and further expanded upon in the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child (CRC).

must be derived and validated. Existing instruments must be evaluated for their accurate comprehension by men and women respondents. Further methodological research is needed to assess whether and how issues such as question wording and the characteristics of the interviewers affect rates of disclosure.

0. Other Topics

As the Research and Indicators Subcommittee worked through the topics for this document, there were a couple of issues that did not fit well into the identified sections, but that were too narrow to have an entire section devoted to the topic. These issues are too important, however, to be omitted entirely from this document. One issue with serious gender implications is the factors that lead to sex selection against the girl fetus. What can be done to reduce/halt this practice from occurring in some cultures? The second issue is what programs to involve men in reproductive health are doing to redress the imbalance of power between men and women.

Priorities Matrix

A "short list" of priorities for research relating to gender and reproductive health are presented in the matrix below. Members of the Research and Indicators Subcommittee prioritized the research gaps listed in each section by voting, and the identified research gap(s) receiving the most votes was placed into the matrix. When reviewing this list of research gaps, keep in mind that *gender* was the main focus of the analysis. Thus, for each topic, the analysis does not include an exhaustive list of studies needed on the topic, but only the research questions related to gender and the topic.

Identified Priorities for Research Gaps Relating to Gender and Reproductive Health

A. Adolescents		
Biomedical	**Policy/Programmatic**	**Social Science**
To what extent does the immature female genital tract make adolescent girls more susceptible to RTIs/STIs?	What barriers do young women face in using modern-sector reproductive health (RH) services (government, NGO and commercial) - family planning, STIs, safe mother-hood, PAC? Do service providers particularly discriminate against young, unmarried, sexually active women? What barriers do young men face in using modern sector RH services - family planning, STIs? Are the barriers faced by young men different than those faced by young women? Do very young adolescents face different barriers than older adolescents? How do fees-for-service affect adolescent women's and men's use of RH services differently? What RH services do adolescent women and men perceive they need? Have adolescent women and men been involved in the research process in a participatory way? Have both qualitative and quantitative techniques been used to get an in-depth understanding of their needs?	Do adolescent women and men make decisions differently about RH-related issues? What is the balance between individual calculations and outside influences for males and females?

B. Behavior Change Communication		
Biomedical	**Policy/Programmatic**	**Social Science**
	How do existing behavior change communication programs address gender roles and status in the communities and societies where they are in place? What effects do BCC programs have on existing gender norms within communities and societies? How do BCC programs with women's empowerment and gender equity components address or defuse potential community resistance? How successful are communications programs that focus on changing or clarifying values in support of gender equity?	How do mass media, as used in reproductive health and social marketing programs, affect gender images and norms? How do the political and social factors necessary to create a supportive environment for behavior change differ between women and men?
C. Child Survival		
How do pharmacological differences in medications for girl children as compared to boy children affect reproductive health later in life? Does pesticide poisoning during childhood lead to adverse reproductive health problems later in the life cycle?	What are effective ways for health services to encourage gender equitable treatment of girl and boy children? Specifically: - When children are gathered for immunization, how can community members and health workers be motivated to seek out the girls, who may be at home? - How can health services be changed to encourage outreach to girl children for necessary prevention and care? - What can encourage community members important to children to be knowledgeable about and discuss the issues of sexuality and the psychological/physiological/emotional changes that occur during puberty? - What are effective ways to teach mothers/fathers/teachers/community members important to children the knowledge they need to discuss sexuality/puberty? What are ways of encouraging communities to reduce gender inequities in order to improve girls' nutrition?	What factors lead to uneven/ inequitable distribution of food in the household? What impact does this have on reproductive health later in life? What programs can best effect change in this area? What factors contribute to inequitable health resources for girls as compared to boys?

D. Environmental and Occupational Health		
Biomedical	**Policy/Programmatic**	**Social Science**
How does the prevalence of anemia in women impact on the reproductive health risks of environmental and occupational exposures? Are there any reproductive health impacts from exposure to air pollution?	What are the most effective ways to provide women and girl children, particularly those who are illiterate, with training concerning the reproductive health hazards of pesticide exposure? What are effective ways to train health service providers to recognize and treat occupational, environmental or pesticide-related etiologies during reproductive health care?	What are the numbers of women and girl children at risk of pesticide exposure with concomitant reproductive health risks? Which crops, tasks, gendered roles and pesticides place women and girls most at risk? Men and boys? Which occupational and domestic tasks involve differential reproductive health risks for women and men?
E. Female Genital Cutting		
Are women who have had FGC more likely to contract HIV/AIDS? What are the long-term physical effects of FGC for women?	What are the consequences of dealing with FGC in isolation of other gender issues? What is the relationship between family planning and FGC?	Is there a difference in the way men and women approach the issue of FGC? What is the best way to address these differences? What are the reasons behind male reluctance to get involved in combating FGC?
F. HIV/AIDS/STIs and Condom Use		
What incentives can lead to more pharmaceutical products to meet women's needs for cheap, easy methods to detect asymptomatic STIs? What incentives can lead to more pharmaceutical products to meet women's needs to prevent HIV without a partner's knowledge or consent? How can the progress to develop a cheap, easy to use mechanism to identify cervical infections be accelerated?	What are effective ways to involve women and their sexual partners in HIV risk reduction and to maintain risk reduction practices over sustained periods of time? How can the norms of sexual behavior be changed so that: - Men, women, and their sexual partners can discuss sexual relationships prior to intercourse? - Nonconsensual sexual relationships are reduced? - Women can initiate and enjoy sexual relationships? - Risk of acquiring STIs and HIV is reduced? What is the most effective way to provide non-punitive, noncoercive health services to commercial sex workers that will not result in stigmatization?	What are the differences between successful and unsuccessful condom users; both female and male condoms, both heterosexual and homosexual? Do gender issues inhibit the use of condoms used in conjunction with other methods?

G. Infectious Disease and Reproductive Health		
Biomedical	**Policy/Programmatic**	**Social Science**
How can the increased susceptibility of pregnant women to malaria be reduced? What is the biologic interaction between malaria infection and HIV infection during pregnancy? What does this mean for treatment?	What are effective ways to give women and girls knowledge of infectious diseases, especially malaria, prior to their first pregnancy?	What training is effective to promote male support for breastfeeding and male involvement to reduce women's traditional chores to enable breastfeeding? What are current beliefs among different populations concerning infectious diseases, such as malaria and TB, during pregnancy? Are these beliefs different for men and for women? Are patterns of drug distribution different for men and for women for malaria, TB, or other infectious diseases, especially when a woman is pregnant?
H. Infertility		
What types of clinical trials for infertility treatments are being undertaken in developing countries? What research is being done to study the effects of women's and men's exposure to environmental pollutants on fertility? More specifically, is exposure to endocrine disrupters identified as a source of infertility for both men and women?	To what extent are STIs recognized as causes of infertility for both women and men? How does gender influence access to inexpensive treatments for both female and male factor infertility (such as penicillin for the main STIs gonorrhea and chlamydia)? What are the most promising efforts being made to reduce STIs, PID and associated infertility in women and men in various countries? What populations are they reaching? How successful are these efforts?	What are the social consequences of infertility for women and men in various societies? What are women's, men's and families' coping strategies for dealing with infertility in various countries? What are the perceptions of various groups (policymakers, opinion leaders, providers, the public) of the causes of and treatments for infertility? What is the link between the value men and women place on fertility and use of various contraceptive methods?
I. Postabortion Care		
How does the use of different postabortion technologies affect access to services? What is the incidence of complications and effectiveness (completeness of evacuation) of MVA technology when used by non-physicians?	How is the decision made to take a woman suffering from postabortion complications to a health care facility? How can other gender-related barriers, such as travel/transportation, access, and resources be mitigated? What are the gender-related issues that lead to discrimination or punitive treatment of PAC patients? What is the role of the sex of the provider in this?	How do gender factors effect the FP continuation rates of clients who receive contraceptives as part of PAC? How can policy changes reduce the effects of early pregnancy on girls' schooling?

J. Postmenopausal Women		
Biomedical	**Policy/Programmatic**	**Social Science**
What are the pharmacological differences in medications for postmenopausal women as compared to "standard" treatments? What are the norms? Are they explicit when reporting on drug studies is done? What are the rates of HIV+ and RTIs among post-menopausal women, in comparison with men of like age?	What programs and policies have been effective in enabling postmenopausal women to continue understanding the need for and attending gynecological/reproductive health services for pap smears and breast exams? What are effective programs and policies to increase access to health services (both in terms of transportation, costs and work-related health benefits) for postmenopausal women?	What are effective ways to reach post-menopausal women with information and services relevant to their particular needs? What interventions can best address gender-and age-specific inequitable food distribution in the household?
K. Quality of Care		
How does current work in contraceptive development address changes in menstrual patterns related to contraceptive use? What is being done to develop methods that provide dual protection against conception and STIs/HIV? What efforts are being made particularly to develop women-controlled methods?	Do providers consider female and male clients capable of being substantively involved in choices regarding their reproductive health care? How do providers treat female and male clients differently in terms of information and care given?	How do definitions of quality of care in various societies differ by sex, social class, and ethnicity? Do participatory approaches to RH care improve the quality of services? How can women be empowered sufficiently to know what level of quality they should expect and demand?
L. Reproductive Health and Reproductive Rights		
	What strategies can reduce gender-related barriers to accessing RH technologies and services? Has the inclusion of NGOs and women's groups increased accountability? What measures are effective for preventing coercion and promoting choice in RH programs?	How do public education curricula reinforce gender-stereotypical roles by offering different educational content to boys and girls? How do government- sponsored advertisements/ promotions for reproductive health programs/services reinforce gender stereotypes?

M. Safe Motherhood		
Biomedical	**Policy/Programmatic**	**Social Science**
	What can be done to increase women's access to resources so they may achieve proper pre- and postnatal care and have access to services for safe deliveries? What are the differences between male and female providers in how, how often, and the types of pre- and postnatal services that are suggested and/or rendered to women?	How do societal/cultural ideas about where/how a birth should take place effect transport issues, particularly during emergencies? How are decisions made within a family to provide the resources for pre- and postnatal services, and/or for emergency transportation if necessary? How does a woman's status and role within the family/community effect how she will be treated during pregnancy?
N. Violence Against Women		
What is the impact of violence and sexual coercion on women's sexual and reproductive health, including RTIs, HIV/ AIDS, fertility, and maternal health? How do partner abuse and violence against women effect children's health?	How effective are referral systems and programs to integrate violence-prevention and detection into health-care systems? What are the costs, in financial and human development terms, of domestic violence and sexual assault in relation to women's lost wages/productivity, increased public sector spending and decreased participation of women in local and national development (economic, social and community development, political participation)?	What are the dynamics, triggers, and social context of intimate partner abuse in developing country contexts? How do constructions of femininity and masculinity at the family and societal levels contribute to or mitigate abuse? What are the links between violence and women's health-seeking behavior and between violence and use of contraception?
O. Other Topics		
	How are programs to involve men in reproductive health working to redress the imbalance of power between men and women?	What can be done to reduce/halt the practice of selective abortions to female fetuses occurring in some cultures?

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